WORKERS' COMPENSATION INCIDENT REPORT

Please have this form TYPED and e-mailed to the persons on the last page for a claim to be opened. Claims are opened for employees who have sought medical treatment beyond the set medic. Any questions, please call Sharon at 323-533-6257.

Date of Injury:_________ Time of Injury:___________ AM PM or Time Unknown:

Reporter Name: ________________________________ Reporter Phone Number

I. INFORMATION ABOUT AFFECTED PERSON

Full Name of Injured/Ill Person ("Affected Person"): ____

Home Address: ____

City:________________________ State: ______ Zip: ___________ Marital Status: ___________

Cell Phone:

Email: ___________________ Social Security #: _________________Gender: Male Female NNon-Binary

DOB: ______________ Job Title: ______________________________ Dept: ______________________
Month/Day/Year

Supervisor's name: _______________________________ Supervisor's Phone No. ____________________

Supervisor's Email: ____

Do you question the validity of this claim? Yes No
If yes, explain:

Is employee off of work? Yes No

Other employees injured or ill in this event? Yes No

Date of Hire: ______________
Month/Day/Year

Employee status (Select One): Regular Part-time Seasonal Other

Did employee miss work beyond their normal shift? Yes No

Employee Start date on production? _______________ Employee End date on production? _______________
Month/Day/Year Month/Day/Year

Network Channel: _________________ Payroll Company: ______________________

Production Title:

II. Please call Sharon at 323-533-6257 for your show's information for the below

*Account Name: ____ *Unit Number: _____________

*Unit Name: ___________________________________ *Unit Address: ___________________________________

*OSHA Report Name: ____

III. LOSS INFORMATION

Exact location of Incident: ___________________________ City:___________________State:____ Zip:_________

Time Employee started work shift: __________ Date Employer was notified: _________________

California Only - Date DWC1 Claim form was provided:__________

Injured Body Part ________________________________ Left : Right

Safeguards/Safety Equipment provided: Yes No

Safeguards/Safety Equipment used: Yes No

IV. INITIAL TREATMENT

On-site Treatment: Yes No Set Medic: Yes No Off-site Treatment: Yes No

Name of Physician:____

Hospital/Healthcare facility name & address: ____

City: _____________________________ State: ______ Zip: ___________

Taken by emergency transportation? Yes No

Admitted to the Hospital? Yes No

Still in the hospital overnight? Yes No

V. RETURN TO WORK

Did affected person return to work? Yes No

Date employee last worked: ____________________

Returned to work date: _______________________

VI. WITNESS INFORMATION

Name: ______________________________________ Address: ____

City: ______________________ State:_____ Zip: _________Email:___________________ ___ Phone: (   ) ____-_____

Comments:

VII. REPORT PREPARED BY:

Name: _____________________________________ Title/job position:___________________________________

Address:____ City:_______ State: ______ Zip: __________

Telephone: (   ) ____ - ____ Email:________________________

Signature: _______________________________________ Date of Report: ______________________

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Please email the completed form to:

Barrie.Wexler@paramount.com
Sharon.Brennan@paramount.com.
Cristen.nixon@fairlygroup.com